Catholic Health

Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the end of this notice, and how I may obtain access to and control this information.

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Signature of Patient or Personal Representative

______________________________ ______________________

Print Name of Patient or Personal Representative | Date/Time

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Description of Personal Representative's Authority

______________________________ ______________________

Signature of Facility Representative | Date/Time

Admission Forms - SCAN, NOTICE OF PRIVACY PRAC, 3/1/22